Writers' views on September 11

For most of us, who knew no one in or near the twin towers, September 11 was just like the worst kind of summer blockbuster—like *Godzilla* or *Independence Day* or *Pearl Harbor*—impossible by its scale to ignore, but equally impossible to see the point of. Why did it happen? What did it mean?

It is this—the quest for meaning—which has us picking through the rubble for months, working through the powdered concrete of ground zero in the hope of finding a recognisable smear of DNA. And when that hope evaporates it is presumably the quest for meaning that prompts the *New York Times* to run a series of potted biographies on all of those who perished, searching for the common threads that will somehow bind all those lives that ended on September 11. The result—a four-month long multicharacter epic told entirely in flashback—remains predictably inconclusive.

The *Guardian* in Britain took a different tack. Ingeniously, over the weeks immediately following the disaster, the paper asked a number of novelists to interpret what had happened. It asked others too, of course—politicians, foreign analysts, aid workers, army types, and bomb blast survivors—but the novelists were given the most space. I guess this stands to reason. Novelists know how to put vague presentiments into words. They know how to mould a great mass of research and speculation into something with a beginning, a middle, and an end.

They also, the best of them, do something more than that. The best give their stories a central theme that echoes through every plot strand and is finally paid off by the denouement. This is the philosophical core to the story, the author's message, if you like. Hollywood script doctors call it the controlling idea and set great store by it.

As you might expect, every writer questioned interpreted September 11 differently, inserting a controlling idea particular to his or her own view of the world. For Arundhati Roy it was the climax to a story of the rich dominating the poor, the payback of decades in which the Western powers tried to force consumerism on a poverty stricken developing world while offering no valid alternative. Western hegemony, she wrote, "is like having a government without a healthy opposition. It becomes a kind of dictatorship. It's like putting a plastic bag over the world and preventing it from breathing. Eventually it will be torn open."

To Salman Rushdie, September 11 was part of the saga of Islam's tragic failure to join the modern world. "The only aspect of modernity in which the terrorists are interested is technology, which they see as a weapon that can be turned against its makers. If terrorism is to be defeated, the world of Islam must take on board the secularist-humanist principles on which true modernity is based and without which their countries' freedom will remain a distant dream."

Richard Dawkins saw September 11 as the final dangerous convulsion of the religious fundamentalism against which, as an evolutionary biologist, he has battled for years.

J G Ballard saw further proof of the "latent psychosity lurking behind everyday life." And Joan Didion saw it as the end of America's profound parochialism. "On September 11," she wrote, "my sense is that the world didn't change so much as America entered it."

I find myself in agreement with all these writers. I find comfort and instruction in every retelling of the story, with all their different conclusions on the kind of people we should now be, the sort of world we should now strive to create. But the one story I have not yet read—and perhaps it deserves an airing—is the story in which September 11 is not the beginning, the middle, or the end of anything. I suspect this to be the view of the majority: the voiceless people of the third world who experience on a daily basis the meaningless attrition of AIDS, war, famine, or infectious diseases. Their understanding is that random, horrible, and often violent deaths occur out of the blue. That's just the way the world is. There's no point in trying to find meaning in it, because there's nothing we can do about it anyway.

Bad things happen, and what occurred that terrible day in Manhattan is no more significant, more tragic, nor more meaningful than the equivalent, the much larger massacres, that continue to happen in places you hardly ever read about.

CHAO SOI CHEONG/AP PHOTO

"What occurred that terrible day in Manhattan is no more significant, more tragic, nor more meaningful than … the much larger massacres … you hardly ever read about"

John Collee *a Sydney based writer*

War or Health? A Reader

Ed Ikka Taipale et al

Zed Books, £16.95/$29.95, pp 652
ISBN 1 85649 951 0

Rating: ★★★★

Finland may be a small country without any enemies, but it has produced a rather huge book on health and conflict, which will be invaluable to health professionals and policy makers.

The recent surge (if a growing trickle can be called that) of interest in health issues arising out of conflict follows a brutal century, in which 107 million people have died as a direct result of war. This book—from the Finnish Physicians for Social Responsibility—covers everything from the health effects of different arms systems, to the demographic and social consequences of war, to the concept of conflict prevention and management. But it is only part of the coordinated, systematic response to the health consequences of conflict that is needed from academics, non-governmental organisations, and others.

War or Health? is an apt title for the book. The volume is a testament to why health professionals should be among the leaders in preventing war. Fittingly, the opening paper by Christian Jennsen highlights the important role that doctors have played in antiwar efforts since the 19th century. It describes the activities of the German pathologist Rudolf Virchow, who opposed the "blood and iron" politics of Bismarck, up to the activities of the International Physicians for the Prevention of Nuclear War, whose work was so influential in raising the alarm over the buildup of nuclear arms.

But more needs to be done. Epidemiological monitoring of the effects of conflict is one of the technical tasks, as Jennifer Leaning and collaborators note. Most information currently comes from military databases, whose main purpose is to improve the killing power of forces. Humanitarian epidemiology will need to take place to prevent more horrific weaponry being developed. Progress has already been made in this area with the banning of blinding laser weapons.

With the numerous conflicts in the developing world in the 1990s, there could have been more on the connections between war, violence, and underdevelopment. The recent work by the economist Frances Stewart is a breakthrough in this field. There could also have been analysis of the mental health questions that arise from conflict. For example what drives people to terrorism? What kind of mind can devise such brutal killing machines as antipersonnel landmines? How can we better understand the forces that drive genocide?

This remarkable book deserves the bouquets thrown at it by World Health Organization director general Gro Harlem Brundtland and United Nations secretary general Kofi Annan. But as Meri Koivusalo's depressing paper points out, the UN's role as an arbiter in conflict issues is increasingly under threat. Its influence is shifting to the less representative and democratic forums of the G8 and NATO. War has been limited by the international agreements of the Geneva Conventions, the human rights covenants, and more recently the International Criminal Court. However, the international community (led by the UN) could impose further strictures on the actions that are currently permitted in war. Who knows, in the end war itself could be completely abolished. To this optimistic end, health professionals could sign up to a new campaign, the Movement for the Abolition of War, recently launched by Robert Hinde and Nobel peace laureate Joseph Rotblat. Read *War or Health?* and you will need no convincing.

Michael Rowson *director, Medact*

At The Side of Torture Survivors: Treating a Terrible Assault on Human Dignity

Eds Sepp Graessner, Norbert Gurris, Christian Pross

Johns Hopkins University Press, $46.50/£31.50, pp 218
ISBN 0 8018 6627 8

Splintered Innocence: An Intuitive Approach to Treating War Trauma

Peter Heinl

Brunner-Routledge, £15.99, pp 170
ISBN 0 415 22363 6

Rating: ★★★; ★★

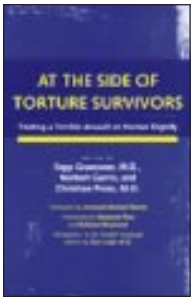
At a meeting in 2000 the Royal College of Psychiatrists debated the existence of post-traumatic stress disorder (PTSD). The debate missed the point. In my experience of working in conflict areas it is perfectly possible to bag up people's presenting clusters of symptoms in this particular way. However, this label rarely serves a useful purpose. It fails to embrace the moral, social, and political dimensions of suffering. Nor does it point to a definitive treatment option.

It was refreshing, therefore, to see that the Berlin Centre for the Treatment of Torture Victims finds labels such as complex PTSD or disorders of extreme stress too constricting and pathologising. It advocates a flexible, multidimensional approach that includes addressing communities' economic and material needs, as well as physical and psychological symptoms.

At the Side of Torture Survivors documents the first four years of the centre's work. The founders make their political agenda explicit throughout by confronting the unacknowledged complicity and silence of the medical profession in the mass annihilations of the second world war.

Pross's detailed case history of a former political prisoner from the German Democratic Republic is an excellent example of how society has the power to award or deprive someone's suffering of meaning and determine his or her wellbeing. The man's psychological wellbeing waxed and waned according to the vicissitudes of post-unification political developments.

In contrast, *Splintered Innocence* is curiously decontextualised. Heinl investigates the impact that German children's experience of war has on their adult life.



My own research with Bosnian Serb adolescents suggests that children perceived by the wider community as living on the side of the perpetrator of a conflict have special problems that need addressing on a communal and individual psychological basis. By focusing on German children's commonalities with other groups affected by war, rather than of the specificities of growing up in that political context, Heinl misses an opportunity.

Beyond the powerful stories of war, what stuck in my mind at the end of reading both these books was the ethnographic description of the everyday life of asylum seekers in Germany by Frank Merkord, a social worker at the Berlin centre. They are deprived of personal possessions, freedom of movement, privacy, meaningful activity, and contact with family or friends.

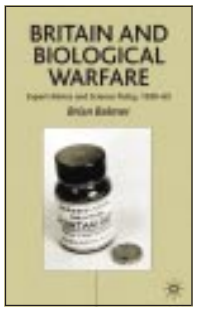
Atrocities that are not acknowledged require no response. If we are serious in our desire to end "terror" in all its forms, it will require much more than the ability of specialist centres to acknowledge, believe, and validate the suffering. The rest of us will have to start paying attention as well.

Lynne Jones *child and adolescent psychiatrist, medical director of the child psychiatry programme in Kosovo for Child Advocacy International*

Items reviewed are rated on a 4 star scale (4=excellent)

Britain and Biological Warfare: Expert Advice and Science Policy, 1930-65

Brian Balmer



Palgrave, £45, pp 246
ISBN 0 333 75430 1

Rating: ★★★

In the *London Review of Books* recently, Hugh Pennington, professor of medical microbiology at Aberdeen University, suggested that the big puzzle about anthrax was that terrorists had so far used it so little. Contrary to the reassuring propaganda about the difficulties of preparing spores and preventing them clumping, he reckoned that anyone who had had some basic training in bacteriology could do it.

Even before contaminated mail caused the outbreak of anthrax in the United States last year, disaffected groups had attempted to cause harm using biological agents. In 1985, more than 700 people in Oregon developed salmonella gastroenteritis after a religious cult deliberately contaminated salad bars. These kinds of outbreaks are extremely successful in causing civic disruption even when the number of cases falls short of terrorists' expectations.

This book, however, is about a period when the threat of biological attack came not from shadowy terrorist organisations but from nation states with expansionist policies. In 1934, a former editor of the *Times*, Henry Wickham Steed, claimed that German spies had been testing biological warfare agents on the London underground and the Paris metro. The British government took his allegations seriously. By the time war was declared in 1939, extensive secret preparations for defence against a germ warfare attack were in place. Vaccines and sera had been stockpiled and an emergency public health laboratory service established.

Within a year, the emphasis on defence had shifted to the creation of a retaliatory capability. A plan was devised to infect German livestock by dropping from the air linseed cattle cakes contaminated with anthrax. Five million cattle cakes were manufactured and special hoppers designed that could be attached to aircraft to carry and discharge the cakes over agricultural ground.

At the same time, experiments with rudimentary anthrax bombs on Gruinard Island off the west coast of Scotland showed that spores could survive detonation. Indeed, an outbreak of anthrax among sheep on the nearby mainland following the tests, probably caused by an infected carcass being washed ashore, threatened to compromise the secrecy of the project.

After the war, there was rapid expansion of research into the possibilities of using biological agents as weapons of mass destruction. Although this was partly a response to anxieties about Soviet capabilities, arguments that biological weapons would be cheaper than and perhaps complementary to atomic bombs also influenced policy. There were ambitious plans for the development of a biological bomb and the building of experimental plants for the production of large quantities of pathogens. This programme gradually became a victim of economic pressures on the national defence budget and an increasing preoccupation with nuclear deterrence. But no cabinet level decision to abandon offensive biological warfare was ever taken.

Britain and Biological Warfare provides no jaunty accounts of boffins devising ingenious weapons to frustrate evil plans for world domination. Instead, it is a thoughtful inquiry into the difficulties of formulating a prudent response to a threat that has been much researched but little used. I think the author takes the view—he is so tentative that it is hard to be sure—that scientific advice about biological warfare has tended to inflate assessments of the risk and urgency of the danger. It would be interesting to know if recent events have caused him to change his mind.

Christopher Martyn *BMJ*

TV

We all fall down: could smallpox return?

Smallpox 2002—Silent Weapon, BBC2, Tuesday 5 February, 9 pm

The world has been free from smallpox since 1980. The last outbreak occurred in 1977, it was successfully contained, and the eradication campaign passed into the history books as one of the 20th century's greatest achievements. Governments then wound down their vaccination programmes, and the human race moved on, untroubled by *Variola major* but also increasingly defenceless against it as the immune populations died out. Last Tuesday, a BBC broadcast dramatised what would happen if a terrorist deliberately unleashed a virulent strain of smallpox on a now virgin population.

Smallpox 2002—Silent Weapon is a fictional account of a smallpox pandemic in which 60 million people die and three times as many become ill. Civil unrest, martial law, and economic collapse follow the virus across the globe as civilisation's infrastructure collapses under the weight of the dead and dying. The story begins in New York with a single case. An uncontrolled epidemic quickly follows because doctors don't recognise the disease, and officials don't act fast enough when they do. Within a few days smallpox spreads across the Atlantic, then to the rest of the world. The devastation is greatest in Africa, where the combination of AIDS and smallpox kills nine tenths of those infected.

Slowly, it becomes apparent that the outbreak was an act of terrorism. Investigators find an infected body in Grand Central Station, then a key to a hotel room, then a Bible open at Ezekial, chapter 5, verse 12: "A third of thee shall die with the pestilence." The lethal pandemic was caused by a single Godfearing American with a grudge. DNA fingerprinting of the virus type found on his body leads the investigation to a Russian laboratory where military leaders stockpiled the virulent strain "India 1" during the cold war. It's not clear how the terrorist acquired his supply, but the disturbing truth is that Russia's economic collapse at the end of the cold war made its military laboratories decidedly leaky.

The BBC billed the programme as a docu-drama, a sometimes confusing hybrid of two very different styles. The documentary label encourages viewers to believe what they see, while the term "drama" gives the producer licence to embellish the facts for dramatic effect. It's a powerful if slightly dishonest combination, and one that kept me glued to the screen until the end of the 90 minute broadcast. Intrusive questions then disturbed my daily routine for several hours. Did the Russians really stockpile smallpox virus India 1? Is there really an army of disaffected Russian scientists selling smallpox to the highest bidder? And can you really culture smallpox in the kitchen with a home brewery kit?

Telltale shots of New York's World Trade Center indicate that the programme was conceived and produced before the terrorist atrocities of 11 September, but the subsequent paranoia about terrorism must have increased its impact. Viewers who find themselves unable to sleep might be reassured, as I was, by the US Centers for Disease Control and Prevention. On the website are detailed plans for the management of a terrorist attack with smallpox, mathematical models of an epidemic's likely behaviour, and the promise of enough smallpox vaccine for everyone in the United States by the end of 2004. All documents have been updated since 11 September. If there is a madman out there with a Bible and a Petri dish the Americans, at least, are ready for him.

Alison Tonks *freelance medical journalist*

Focus on Afghanistan

MARTIN ADLER/PANOS PICTURES

The media continue to provide detailed coverage and analysis of the situation in Afghanistan. Web coverage extends this further and offers the opportunity of getting information "straight from the horse's mouth." Discussion forums on all the major search engines—for example, at http://groups.google.com/groups?hl=en&group=soc.culture.afghanistan—also provide the chance to engage in debates over subjects such as: what is the American economic interest in Afghanistan? Can war be justified? Is religion the root of war? How should the current humanitarian crisis be handled?

The main focus of much internet attention is now on reconstruction and the provision of humanitarian aid. In the "reconstructing Afghanistan" area of www.worldbank.org you can read World Bank news stories and reports on the estimated levels of aid required for reconstruction. You can also access the findings from reconstruction conferences held in Bonn and Tokyo. The UK Department for International Development at www.dfid.gov.uk/ has links to situation reports posted every few days and details UK action. For example, the UK government has recently promised £300m to the United Nations trust fund to support reconstruction and the salaries of the interim government.

The UN's section on Afghanistan (www.un.org/apps/news/infocusRel1.asp?infocusID=16&Body=Afghanistan) contains links to aid agency programmes, reports, and a photo gallery of the UN's activities in the country. More than 100 staff are now working there and all regional centres are staffed. The main activity is to encourage disarmament in the areas beyond cities, where lawlessness and instability are rife. For in depth economic analysis on the level of aid provision visit the European Commission at http://europa.eu.int/comm/echo/en/whatsnew/afg.htm and the United States Agency for Development at www.usaid.gov/about/afghanistan/

For information on the activities of aid and government agencies, Assistance Afghanistan (www.pcpafg.org) is a good site. Currently more than 50 organisations are present in the country—and all can be accessed through the "organisations" link bar on the home page. The site also gives you the opportunity to donate to the UN Afghan Emergency Trust Fund, which supports the UN humanitarian/relief efforts in Afghanistan and Afghan refugees in Pakistan. You can also go direct to aid agencies' sites—for example, the Red Cross (www.icrc.org/eng/afghanistan), Oxfam (www.oxfam.org.uk), and Unicef (www.unicef.org.uk). The World Food Programme site at www.wfp.org estimates that it has provided 200 000 tons of food aid since October to more than 6 million people. Winter conditions, with temperatures as low as −45°C, have been reported on some roads and special bulldozers are being used to get through to displaced people.

The difficulties for aid agencies working in Afghanistan lie in its geography and in its ethnically and linguistically diverse people. www.cia.gov/cia/publications/factbook/geos/af.html gives all the key facts about the country—geographic and health data, economics, and transport facts. Kabul's average temperature in February is −2.8°C, more than 30 languages are spoken in the country, and last year Afghanistan was the world's largest illicit producer of opium. www.afghan-network.net is also one of the best for a cultural viewpoint and fascinates with details of what, beyond the poverty and tragedy, is a culturally rich country.

Human rights issues in Afghanistan

Two good sites for accessing human rights issues in Afghanistan are:

www.pcpafg.org/organizations/Human_rights/index.htm
(the Human Rights Watch, Afghanistan)

http://usembassy.state.gov/afghanistan/wwwhhr99.html
(the US Department of State).

Both agree that women's rights must be prioritised in Afghanistan's reconstruction effort. They urge the interim government to establish laws guaranteeing women's rights to education, political involvement, free expression, mobility, employment, and health care. But they warn that advisory teams require specific funding and are essential in pushing for these protections. Strong political leadership is also vital to push through the extensive reform agenda set out by the United Nations Development Fund for Women (www.unifem.undp.org) after its wide consultation with Afghan women's groups.

Much hope is pinned on Dr Suhaila Siddiqi, the new health minister, who is one of only two women in the interim government cabinet. A visit to the website of the Revolutionary Association of the Women of Afghanistan (http://rawa.false.net/index.html) shows just how badly women need powerful advocates. It graphically catalogues the systematic violations of women's human rights that have taken place over recent years and underlines the urgency of Amnesty International's call for the establishment of a strong independent justice system in Afghanistan (www.amnesty.org).

Alex Vass *BMJ*
avass@bmj.com
Tessa Richards *BMJ*
trichards@bmj.com

NETLINES

- Online journals are establishing a growing presence and a fine example can be found at http://anil299.tripod.com/indexpapers.html. This is a journal of forensic medicine and toxicology and although the site design is simple it exudes enthusiasm. The current issue and archives are easily accessible and in full text at no cost. A clear, well thought out frequently asked questions section adds to the quality of the site. This is an excellent example of what a small group of people can do in what is not a mainstream medical specialty.
- Deep in the recesses of an American military website (http://navymedicine.med.navy.mil/women_health/WomenS_Health_CD/ed2/enhanced/Enhanced%20Version.htm) lies a jewel of a resource. This is the second edition of an obstetrics and gynaecology textbook. Although the book is designed for use in a military or combat situation, it is of great relevance to standard practice. Despite the long URL, this is an excellent site. The main subject headings are converted into hypertext links, making it well worth a look. The section on the prisoner of war experience is particularly worth reading.
- The Unicef UK baby friendly initiative has a super site at www.babyfriendly.org.uk/home.htm. It looks at promoting and supporting best practice for feeding babies, in particular breast feeding. The main page gives clear statements of the site's purpose and navigation is simple yet clear. There is plenty of information here, including a resource file and an excellent links section. This is an ideal site for both patients and health professionals alike.
- The University of Pennsylvania Medical Centre's Guidelines for Antimicrobial Therapy at www.uphs.upenn.edu/bugdrug/antibiotic_manual/table%20of%20contents.htm is a useful collection of resources. HIV, tuberculosis, and bioterrorism are among the topics that are well represented. Since infectious diseases are a feature of many medical disciplines, this page will be of interest to a wide number of health professionals.
- The Cairns library in Oxford (www.medicine.ox.ac.uk/cairns/clic/) offers a practical set of links. These include guidelines, online databases, and a handy collection of search engines, among them a subgroup of medical and health search facilities. There is even a separate listing of newly added listings, labelled with a date. This makes it interesting for the visitor to return and see the latest offerings. It is also evidence that the owners regularly update the page.

Harry Brown *general practitioner, Leeds*
DrHarry@dial.pipex.com

We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address

PERSONAL VIEWS

How war affected my life and work

After two years of war in Kosova, air strikes began in Prishtina. I lived through three months of extreme anxiety. Every day I expected to get killed by the Serbian police, the paramilitary, a soldier, or even a neighbour. I remember listening to the BBC news, hearing horrific stories of civilians who were killed and buried in mass graves: young people, old people, women, and children. Nobody was safe, not even the politicians who were supposed to have immunity under international law. For the first two weeks I didn't go out at all, not because I felt safe at home, but because I wanted to be near my family in case something happened.

I was so anxious during those three months that sometimes I felt as if my head would explode. I was sure that we would all get killed, but hoped that by some miracle my children would survive, or that I would be killed before anything happened to them. I couldn't think straight. I couldn't eat. I could only take care of my children and watch the news, hoping that the war would end soon.

I was so anxious during those three months that sometimes I felt as if my head would explode

My 3 year old son realised that something very wrong was going on. Even when sleeping, he would wake up when there were shootings or bombings, and would ask me what was going on. I would give him a vague answer. I don't remember exactly what. Something like the shootings have nothing to do with us, that it was the police shooting in the air, or that the NATO aeroplanes were bombing the bad tanks. Every time I saw fear in his big brown eyes I felt guilty. I felt guilty for deciding to stay in Kosova during air strikes.

SANTIAGO LYON/AP PHOTO

A mother and child, refugees from Kosova, enter Albania, May 1999

We survived and the war ended. I started my training in psychiatry. It was a dream come true. During the war I had thought that if I survived I would become a child psychiatrist.

Ferid Agani, a senior colleague who was trying to reform the mental health services, introduced me to Lynne Jones, a child and adolescent psychiatrist from England. With the help of CAI (Child Advocacy International) she was trying to establish child psychiatry services in Kosova. Lynne was interested in training somebody who was really interested in working with children.

That was a second dream come true for me. But instead of feeling happy I had doubts whether I had made the right choice. I felt that I was too sensitive, especially to war trauma.

Whenever people spoke about the horrific stories from the war I would find some excuse to go away. I didn't want to believe them, because it was too painful.

Then one day a mother brought her 9 year old son to our clinic. She told us how her younger son had been killed. A sniper had shot him in the throat while he sat in her lap. The same bullet wounded the mother in her arm. The terrified child screamed for about half an hour, knowing that he was dying. The mother had put him on the ground hoping that he would die in peace, but the Serbian paramilitaries came in, pushed her aside, and started kicking the dying child. There was no denying this time. I identified with her. I had two sons myself and every day of the war I had been afraid that they would get killed.

I still remember how hard it was to control my feelings and not start crying in front of this woman who was trying to hide her own tears from her son, who had witnessed his brother's death. In our culture crying is considered a weakness and it is embarrassing to cry in front of other people. People also expect therapists to be strong. If I had cried I am sure that she would not have come back. Thankfully I was not conducting the interview and eventually I did pull myself together. I cried all the way back to Prishtina.

I never thought that I would be able to listen to similar stories, but I did. With time I learnt to deal with my feelings and to use my experience and knowledge to help my patients. I don't have doubts any more. Now I am sure I made the right choice.

Aferdita Goçi-Uka *child psychiatrist, Prishtina*

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

Disappearing hospital

The hospital is disappearing day by day. I sit by my bullet holed kitchen cabinet and watch it through my large picture window—a liability during the 1992-5 siege, but a real estate asset now. Then, mortars poured down on this old hospital from the hills around Sarajevo. It burnt down and, when the last sniper withdrew, Sarajevans salvaged the plumbing, tiles, and the best of the bricks. Now, during the week, staff from the rebuilt nearby state hospital park their cars. During the weekends, families forage in the rubble and squeeze out little vegetable plots, teenagers play basketball and romance, my children roller blade, and I sit on the safest piece of wall discussing life with my husband.

Hospitals are like coral reefs. On a lifeless shell arises a teeming and complex ecosystem of people, lives, and events. This seems real, solid, and everlasting. My life as a young doctor in Dublin was so caught up in Trinity College teaching hospitals that it was unimaginable to think of them ending or closing. Sacrilege to imagine that history—that memory holding of people's lives, deaths and dreams—could be swept away in the name of efficiency. Yet close they did—Sir Patrick Dun's, the Adelaide, the Meath, Mercers…

RIKARD LARMA/AP PHOTO

Waiting for treatment after a mortar blast, Kosevo hospital, Sarajevo, August 1995

As I get older and directly involved in planning health services, I can provide sensible and rational arguments about why it might be best to close a hospital or move it elsewhere. But at another level it hurts and offends me. In the midst of a planning exercise to close an old small hospital in London during the 1980s I was pained to see a little bunch of placards outside the House of Commons protesting against the closure of the hospital in Liverpool where I had been born. Somewhere another planning committee had made the rational, logical decision for this closure. My emotions won and I joined the picket line for a while.

At least the passing of hospitals in peacetime can be discussed, planned, and managed. In war the passing of hospitals is disgusting. During the war in Croatia, and Bosnia and Herzegovina, hospitals were directly targeted to force their catchment populations to move. Patients and staff in Vukovar's main hospital were massacred when the city fell, a guided mortar hit and killed eight patients having lunch in Bihac hospital, and a surgeon was decapitated by a mortar at the entrance to the operating room in Sarajevo's Kosevo hospital. I have vivid pictures of walking through knee high piles of half burned handwritten medical notes, and standing in a trashed operating room adorned with obscene graffiti and beer bottles, its walls smeared with shit. Professional lives had been spent in these hospitals and now all traces of them were scattered in rubbish, rubble, and graves.

Enthusiastic donors have rebuilt many hospitals in Bosnia and Herzegovina, usually in exactly the same out of date and irrelevant original design. The health staff and donors could neither envisage a new structure nor let go of the old one lost so painfully. Sometimes hospitals have been rebuilt bigger and better, and are now half empty. Sometimes they are in the wrong place or have been replicated on either side of an ethnic divide, and now public funds can barely sustain them. All have been recolonised with new lives and events. A sort of *Chicago Hope* soap opera of the Balkans runs on here.

So I sit at my kitchen window as the seasons change. Snow comes and goes, as do health ministers, health planners, and a dwindling bunch of donors set on rebuilding the buildings. Our disappearing hospital is not on the rebuild list and we colonise its ruins and await its fate. It is part of the post- war city organism, a wound that has fed on sorrow in a strangely creative way, and which celebrates the vitality of Sarajevo and the Sarajevans that live round it. The trees get taller, birds nest, cars park, the national team and local teenagers play basketball, older people gather to compare vegetables from the makeshift allotments, the best bricks are now part of local house repairs.

Our disappearing hospital is a dynamic living monument. I already miss it in the way that I miss my own life and the lives of my husband and children that will, in turn, disappear. During the last days of summer, the bulldozers moved in to level it. The planning committee spared the basketball hoop but flattened the vegetables.

What next?

Mary E Black *Children in Need of Special Protection Measures, Unicef, Sarajevo, Bosnia and Herzegovina*

SOUNDINGS

Teaching hospital teams

We meet in the morning for consulting rounds. "How is Mr Jones ?" I ask. "Oh, he is Irene's patient, and she is in the clinic," answers another resident.

We go to see Mr Jones. Manuel, the intern on the primary care "team," has the day off. The resident cannot present the patient because he was off last night. The student who worked up the patient is at a lecture. "Jones really belongs to Manuel, and we are only covering for him," says another resident. Later we communicate with other "teams" on equally vague terms.

After lunch, the clinic. Some 50 patients are waiting. Irene is here, but three other residents are missing. Joan has her own separate "continuity" clinic. Joe has been assigned to escort a residency candidate around the hospital. Larry was on-call last night and, according to regulations, has to be off that afternoon. We finish late.

At weekends Irene covers the service. But only until 5 pm. Then comes another resident, who does not know the patients. He will endorse them the next morning to Joan, who at 5 pm will endorse them to Manuel, who will endorse them to the "team" on Monday.

After one month most residents leave the service. They endorse the patients to a new "team" and move on to another one month rotation, an awkward arrangement made necessary by the multitude of regulations promulgated by the residency accrediting boards. As a result some service chiefs now have to orient new residents 12 times a year, constantly issuing handouts and curricula to inexperienced house officers whom they hardly have time to get to know.

Monthly rotations have also spawned an "evaluations industry," with forms being constantly sent out, filled in, signed by everybody concerned, sometimes lost, then traced and filed.

All these arrangements are made in the name of better education and patient care. But for continuity of care they do very little. Ask a patient who was his doctor in a teaching hospital and he will tell you there were so many that he couldn't tell. But there is more to come. A well meaning representative has introduced another bill in Congress. There will be more regulation, more patient "protection." Residents will have to have at least 10 hours off between shifts. And more patients will be lost in the system.

George Dunea *attending physician, Cook County Hospital, Chicago, USA*